Salem Chiropractic Clinic

Brian D. Herren, D.C.
1765 State Street • Salem, Oregon 97301 • (503) 763-3528

Motor Vehicle Crash Questionnaire

Full name: _____ Today's date: _____

History of Crash/Subjective Complaints

History of Occurrence

Date of crash: _____Time:_____ ▫ a.m. ▫ p.m. Were you alone in the car? ▫ yes ▫ no

▫ Driver Passenger: ▫ front right ▫ front middle ▫ rear right ▫ rear middle ▫ rear left

Driver of car: _____ Who owns the car?_____ Year and model of car: _____

Where was the crash? City: _____Street:_____Cross street:_____

Direction of travel: _____

Visibility at time of crash: ▫ Poor ▫ Fair ▫ Good

Road conditions at time of crash: ▫ Icy ▫ Rainy and wet ▫ Clear ▫ Dark

If other vehicles were involved, type of vehicle(s): _____

Please tell us about the crash: Was it a rear impact, front impact? (note the car you were in as car "A")

_____

_____

_____

_____

_____

_____

Did the police come to the crash scene? ▫ Yes ▫ No

Did an ambulance come to the crash scene? ▫ Yes ▫ No

Were you transported by ambulance to the hospital? ▫ Yes ▫ No If yes, which hospital? _____

What was the approximate damage done to the car you were in? $ _____ Was it driveable? ▫ yes ▫ no

How much damage was there to the other vehicle? _____ Was it driveable? ▫ yes ▫ no

Impact/Seat Belt/Headrest/Speed

Seat belt use: Were you wearing a ▫ Lap belt ▫ Shoulder belt ▫ Both ▫ No belt worn

Were you prewarned that the accident was about to happen? ▫ Yes ▫ No

Did you brace for the impact? ▫ Yes ▫ No

Does your car have headrests? ▫ Yes ▫ No

Impact/Seat Belt/Headrest/Speed (continued)

If your car does have headrests, what was the position of those headrests compared to your head before the accident? ▫ Top of headrest even with bottom of head ▫ Top of headrest even with top of head ▫ Top of headrest even with middle of neck

Was your car braking? ▫ Yes ▫ No Was your car moving at the time of accident? ▫ Yes ▫ No

If your car was moving, how fast would you estimate you were going?____MPH (estimate)

How fast was the other car traveling?_____MPH (estimate) ▫ Don't know

Head/Body Position

Head/body position at time of impact: ▫ Head turned left ▫ Head turned right ▫ Head looking back ▫ Head forward ▫ Body straight in sitting position ▫ Body rotated left ▫ Body rotated right

Position of right and left arms at time of impact (ie: on steering wheel) _____

Position of right and left feet at time of impact (ie: on brake) _____

Did the impact cause your seat back to slip backward or break? ▫ Yes ▫ No

Describe, in your own words, what happened to you upon impact: _____

_____

At the time of the crash, recall what parts of your head or body hit what parts on the inside of your car:

_____

As a result of the crash, were you: ▫ Rendered unconscious ▫ Dazed, circumstances vague ▫ Shaken up, but could function

If you did lose consciousness or strike your head in the crash please fill out the Rivermead questionnaire

Could you move all parts of your body? ▫ Yes ▫ No

If no, what body parts could you not move, and why? _____

Were you able to get out of the car and walk unaided? ▫ Yes ▫ No

If no, why couldn't you get out of the car and walk unaided? _____

Did you get any bleeding cuts or bruises? ▫ Yes ▫ No

If yes, what bleeding cuts did you get from this crash? _____

If yes, what bruises did you get from this crash? _____

Please describe how you felt immediately after the crash (please be specific) _____

_____

Later that ▫ Day ▫ Night _____

The next days: _____

First Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? ▫ Yes ▫ No

If yes, who did you first get treatment from? _____

Date of first visit:_____

Were you examined? ▫ Yes ▫ No Were x-rays taken? ▫ Yes ▫ No

Were you given treatment? ▫ Yes ▫ No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Second Doctor/Hospital/Clinic Seen

Second doctor/clinic seen: _____Date of first visit:_____

Were you examined? ▫ Yes ▫ No Were x-rays taken? ▫ Yes ▫ No

Were you given treatment? ▫ Yes ▫ No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Third Doctor/Hospital/Clinic Seen

Third doctor/clinic seen: _____Date of first visit:_____

Were you examined? ▫ Yes ▫ No Were x-rays taken? ▫ Yes ▫ No

Were you given treatment? ▫ Yes ▫ No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Activities of Daily Living

Do you notice any of your home activities that are different now than from before the accident? ▫ Yes ▫ No

If yes, list them as:

Those activities that you are now unable to do (be specific): _____

Those activities that are now painful to do (be specific): _____

Those activities that are now difficult to do (be specific): _____

Work Status History

Have you missed time from work? ▫ Yes ▫ No Unable to work since the crash? ▫ Yes ▫ No

If yes, full time off work: _____ If yes, part time off work:_____

Prior Similar Complaints

Did you have any physical complaints before the crash? ▫ Yes ▫ No

If yes, what physical symptoms did you have before the crash? _____

_____